AQAF
THE BUSINESS OF QUALITY

Quality Improvement Organization Program

Medicare's Quality Improvement Organization (QIO) Program demonstrates the Centers for Medicare & Medicaid Services' (CMS') commitment to consistent, high-quality care for Medicare beneficiaries across the country. The Program—originally known as the Utilization and Quality Control Peer Review Organization (PRO) Program—was created by the Social Security Act, as amended by the Peer Review Improvement Act of 1982. The Program's statutory mission is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. In the early years, PROs conducted medical record reviews to ensure that Medicare was paying for medically necessary care, while doing limited quality improvement work in the form of patient case reviews. In the early 1990s, the PRO Program evolved into the QIO Program following a landmark study of the Program by the Institute of Medicine, and was given a significantly enhanced mission to drive health care quality improvement.

Under the direction of CMS, the QIO Program now consists of a national network of 53 QIOs, responsible for the 50 U.S. states, the District of Columbia, Puerto Rico, and the Virgin Islands. QIOs work with consumers and physicians, hospitals, nursing homes, and home health agencies to refine care delivery systems to make sure patients get the right care at the right time, particularly patients from underserved populations. QIOs also help safeguard the integrity of the Medicare Trust Fund by investigating beneficiary complaints about quality of care and using the complaints as a basis for implementing targeted quality improvement initiatives with individual health care providers.

QIO contracts with CMS run in three-year cycles. In August 2008, the Program completed the 8th Statement of Work (SOW) contract cycle and embarked on the 9th SOW contract cycle.

During the 9th SOW contract period, the QIOs are focusing on four main Themes:

1. Beneficiary Protection – reviewing the quality of care provided to beneficiaries and implementing quality improvement activities as a result of case review activities.
2. Patient Safety – working with hospitals and nursing home to improve performance on a set of important processes and results that will reduce patient risk factors.
3. Prevention – improving immunization rates for influenza and pneumonia as well as key cancer screenings. Some QIOs will also work to improve care for chronic kidney disease patients and/or work to reduce health disparities for specific underserved populations.
4. Care Transitions – selected QIOs will work on encouraging the coordination of care across the spectrum of health care; promoting seamless transitions from the hospital to home, skilled nursing care, or home health care; and promoting efforts to reduce unnecessary rehospitalizations in specified regions of several states.

In addition, through their work in the above Themes, the QIOs help CMS promote and achieve three overarching goals for American health care:

1. Adoption of value-driven health care.
2. Supporting the adoption and use of health information technology.
3. Reducing health care disparities.

The QIOs are valuable national resources that continue to help CMS drive the movement for quality. QIO staff and CMS look forward to working closely with providers, partners, and consumers to reach greater heights in health care quality in the coming years.

For more information on the QIO Program, please visit **www.aqaf.com**.

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